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ABSTRACT

The Child and Family Resource Program (CFRP) is a family-oriented child development program initiated by the Administration for Children, Youth and Families to provide support services to low-income families and their children. This report summarizes preliminary findings based on the first year and a half of CFRP evaluation. Following the brief description of program objectives and evaluation phases provided in chapter 1, chapter 2 presents an overview of the CFRP demonstration along with preliminary findings concerning the program operations and processes used in working with families. In addition, this chapter identifies models of program organization and delivery services adopted by various program implementations. Chapter 3 examines the impact of CFRP on families and children by comparing participating families with a group not enrolled in CFRP. Chapter 4, which concludes the document, provides a discussion of future study issues and preliminary plans for the next phase of the CFRP evaluation. (MP)

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EVALUATION OF THE CHILD AND FAMILY RESOURCE PROGRAM (CFRP)

Phase III Executive Summary

March 10, 1981

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Chapter 1

INTRODUCTION

In 1973, the Administration for Children, Youth and Families (formerly the Office of Child Development) initiated the Child and Family Resource Program (CFRP) as part of the Head Start Improvement and Innovation planning effort. CFRP was funded as a demonstration program with the intent of developing models for providing services to low-income families with young children--models which could be adapted by different communities serving different populations.

CFRP is a family-oriented child development program which provides support services crucial for the sustained healthy growth and development of families who have children from the prenatal period through age eight. It promotes child development and meets children's needs by working through the family as a unit and provides continuity in serving children during the major stages of their early development. This is accomplished through three program components:

- an infant-toddler component serving parents and their children in the prenatal-through-three age range;
- Head Start for families with three- to five-year-olds;
- a preschool-school linkage component to ensure smooth transition from preschool into the early elementary school grades.

Another distinctive feature of CFRP is its emphasis on a comprehensive assessment of each family's strengths and needs and the development with the family of an individualized plan for services to be obtained through CFRP. Families en-

rolled in CFRP receive the same comprehensive services that are offered by Head Start and additional services tailored to the needs of each family. At the same time, CFRP works to reduce fragmentation and gaps in the delivery of services by existing community programs and agencies.

The CFRP Evaluation

In October 1977, the Administration for Children, Youth and Families funded a longitudinal evaluation to determine the effectiveness of the Child and Family Resource Program.* The evaluation is designed to address three major policy questions:

- What is the nature and extent of services that should be provided to families and children in order to meet their needs, enhance their strengths and foster independence?

- What are effective processes for the provision of the services?

- What can be learned about the developmental processes of families and how they relate to the developmental processes of children?

The CFRP evaluation incorporates four component studies--program, impact, process/treatment, and ethnographic--which are complementary ways of viewing the effects and effectiveness of CFRP.

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*The current evaluation was preceded by two other studies of CFRP, both also funded by ACYF. The first, conducted by Huron Institute in 1974-75, was an effort to determine the feasibility of a summative evaluation of CFRP. A formative evaluation of CFRP was also undertaken in 1974-75, by Development Associates Inc.; a follow-up study was conducted by the same contractor in 1975-77.

The program study is designed for purposes of developing a comprehensive picture of the operations of CFRP. Information collected during site visits and in interviews with program staff is used to develop profiles of program implementation and to identify models of certain aspects or operations of the program. The program study establishes a descriptive context for the statistical and analytic findings of other components of the evaluation. Program study site visits took place at three time points: fall 1978, spring 1979, and spring 1980.

The impact study is designed to determine the effects of CFRP services on families and children. Program impact is assessed by comparing CFRP families with a group not enrolled in the program. This study is carried out at six of the eleven CFRPs. These six programs were not randomly selected; they were chosen on the basis of their ability to recruit the requisite number of families for the impact study.

Families entered the evaluation when they had a child less than one year old and were randomly assigned either to CFRP or to a control/comparison group. At entry into the evaluation (fall 1978), there were an average of 39 CFRP and 38 non-CFRP families per site. These families will be followed until the focal child has completed at least one year of elementary school (1985).

Impact data were collected at four time points: fall 1978, spring 1979, fall/winter 1979-80, and spring 1980. Several different data collection methods were used in the impact study: parent interviews; direct assessments of child development; observations of parent-child interaction; and height and weight measures on children.

The process/treatment study focuses on the CFRP families who participate in the impact study at five of the

six sites. This study is designed to explore relationships among characteristics of families and staff, interactions between staff and families, services provided, family participation in program activities, and program impact. Data were obtained through interviews with family workers and an ongoing record-keeping system concerning participation in program activities, goals, and referrals. Interviews occurred at six-month intervals, except in fall 1979.

The ethnographic study, initiated in fall 1980, is designed to provide a more indepth understanding of how CFRP works with individual families and functions as a child development and family support program. The objective of this study is to develop holistic descriptions of CFRP relationships with, and provision of services to, selected families and their children. It examines what happens within CFRP to bring about changes for different kinds of families, as well as the quality of CFRP as it is experienced on an everyday level by individual families and children. The design calls for following eight families at each of the five process/treatment sites for a period of six months. The study involves different types of families (single- and two-parent families, working and nonworking mothers, teenage mothers, and multi-problem families). The study is being carried out by on-site researchers with backgrounds in anthropology or sociology. Data collection is scheduled for completion in spring 1981.

Report Organization

This report summarizes preliminary findings based on the first year and a half of the CFRP evaluation. The findings are presented in two chapters. Chapter 2 provides descriptive information about CFRP programs and their operations, and identifies models used in the delivery of services.

Chapter 3 examines CFRP's impact on families and children by comparing CFRP families with a group not enrolled in CFRP. The concluding chapter provides a discussion of future study issues and preliminary plans for the next phase of the CFRP evaluation.

Further information on the CFRP evaluation can be found in eight reports prepared by Abt Associates Inc. They are:

Phase I

- Design Report, March 1979
- Study Implementation and Preliminary Baseline Profile (Report No. 2), March 1979

Phase II

- Research Report (Volume I), February 1980
- Program Study Report (Volume II), February 1980
- Executive Summary, February 1980

Phase III

- Program Study Report, November 1980
- Infant-Toddler Component and Child Impact Report, December 1980
- Research Report, March 1981

Chapter 2

THE CHILD AND FAMILY RESOURCE PROGRAM

An overview of the Child and Family Resource Program demonstration is presented in this chapter, as well as preliminary findings concerning the operations of CFRP and processes used in working with families. In addition, this chapter identifies models of program organization and service delivery adopted by the various CFRPs.

There are eleven CFRPs across the country, one in each of the ten Health and Human Services (HHS) regions and one representing the Indian and Migrant Division.* Each program receives approximately $155,000-$170,000 per year to serve from 80 to 100 families.

How many families does CFRP serve?

Demand for CFRP typically exceeds supply; most programs maintain waiting lists of families who wish to enroll. Family enrollment is considerably higher than the 80 to 100 mandated in program guidelines. In spring 1979, enrollment averaged 147 families, ranging from the mid-eighties in Oklahoma City and New Haven to over 200 in Jackson.** In addition to their services to families enrolled in CFRP, most programs provide crisis intervention services to non-enrolled families. This kind of service is extensive at some sites and virtually nonexistent at others, where non-enrolled families are referred to other community agencies which CFRP staff believe are better equipped to provide this type of service.

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*Programs are located in Bismarck, ND; Gering, NE; Jackson, MI; Las Vegas, NV; Modesto, CA; New Haven, CT; Oklahoma City, OK; Poughkeepsie, NY; St. Petersburg, FL; Salem, OR; and Schuylkill Haven, PA.

**Not all of the families at all sites are funded 100 percent through CFRP; some are paid for by other program monies.

What are the characteristics of CFRP families?

Two-thirds of the families served by the six CFRPs selected for the impact study* represent ethnic minority groups--56 percent black, 6 percent Hispanic, 2 percent Native American, and 3 percent of biracial background. Two of the six programs serve predominantly white populations.

At entry into CFRP, the mothers' mean age was 27 years. A large proportion of the mothers were between 21 and 25 when they enrolled in CFRP; about 12 percent were under 20, and 5 percent were 18 or under. Las Vegas serves by far the largest proportion of teenage mothers. Most families entered the program at a time when they had children of both infant-toddler and Head Start age, although this differed among sites.

Over half of the mothers have completed high school; the majority are unemployed, except in St. Petersburg. Over a third of the mothers are married or "informally married." CFRP household size ranges from 2 to 14 and averages 4 members. Most of the families have incomes below $6,000 per year, or a per capita income of approximately $1,500. Two-thirds of the families receive public assistance from welfare or AFDC.

How is CFRP organized and staffed?

In most programs, CFRP and Head Start are closely related, yet the nature of the relationship varies from site to site, as does the degree to which the two are integrated. Three models have been identified that illustrate differences in the nature of the relationship between the programs:

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*The six programs are Jackson, MI; Las Vegas, NV; New Haven, CT; Oklahoma City, OK; St. Petersburg, FL; and Salem, OR.

- In the "CFRP-as-Umbrella" Model, Head Start is one component of CFRP. This model is typified by a high degree of integration between CFRP and Head Start.

- In the "CFRP-as-Component" Model, CFRP is a part of Head Start and is under the direction of Head Start staff.

- In the "Separate Programs" Model, there is no direct link between the two programs; each is staffed separately.

CFRPs typically have from 10 to 20 staff members. About half work directly with families. The remainder of the staff consists of program administrators and specialists.

The ethnic makeup of the CFRP staff in most cases corresponds roughly to that of the families enrolled in the program. At four of the six impact study programs, the great majority are black. Staff age ranges from 18 to 76; the mean age for staff is in the mid-thirties. The great majority are married or have been married, and most have children of their own. About a third of the staff have had children in Head Start.

CFRP staff have had between 14 and 15 years of formal education on average. The educational profile of family workers is similar to that of the total CFRP staff. About 40 percent of the CFRP staff have bachelor's degrees, and about 13 percent have master's degrees; however, family workers were less likely than other staff members to have received a master's degree. A larger proportion of the staff have taken non-degree education programs or attended workshops or short courses related to their work. The most popular disciplines include social work and sociology, education, mental health and psychology, and child development.

What types of program activities are offered to families?

CFRP services are offered within the context of the three major program components--infant-toddler, Head Start, and preschool-school linkage. Each is intended to serve families with children in a specific age group; all three taken together are intended to provide continuity, especially developmental and educational continuity, across the period of a child's life from before birth to the primary grades in school.

Infant-Toddler Component

Two types of program activities are offered to families enrolled in the infant-toddler component--center sessions and home visits. The primary purpose of these activities is to enhance the child's overall development and to prepare the child for entry into Head Start.

Center sessions are conducted in two different settings: parent education sessions, intended to provide parents with a basic knowledge of child growth and development and to assist them in developing more effective parenting skills; and infant-toddler sessions, designed to provide children with a group experience, an opportunity to learn to share and get along with others, or to acquire skills. Two models of center-based sessions within the infant-toddler component are currently in operation at the eleven CFRPs:

- The Parent-Child Interaction Model provides extensive opportunity for involvement of parents with their own children at the center. Classroom staff assist parents in working with their children and provide feedback on parent-child interactions. The group discussions that follow focus on topics related to child development or child-rearing practices.

- The Separate Parent-Child Session Model, in operation at most sites, focuses almost entirely on parents, away from their children. Children are cared for in an infant-toddler room while parents attend parent education sessions. There is little or no opportunity for parents to interact with their children at the center.

Levels of family participation in center-based activities are viewed by program staff as "less than optimal." At the five process/treatment study sites*, about half of the CFRP study families (51%) participated in sessions less than once per quarter on average during the year and a half after they entered the program. Participation in center sessions was particularly problematic in Oklahoma City and Las Vegas, where less than one-third of the families attended center sessions regularly. Of the families that came to the center regularly (defined as at least once per quarter), most attended one to three sessions, with an average of 3.4 sessions per quarter. Participation of other families in the study (those attending less than once per quarter) averaged .30 sessions per quarter, or one center session every 12 months.

Home visits are another mechanism for helping parents to strengthen their child-rearing skills and to increase their knowledge about child development. Scheduled frequencies of CFRP home visits range from one to three times per month at the five sites. Home visits occur less frequently than the schedule called for in local program plans.

Another important point is that home visits and center attendance go hand in hand, rather than being alternative or complementary ways in which families take part in CFRP.

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*The process/treatment study sites are: Jackson, MI; Las Vegas, NV; Oklahoma City, OK; St. Petersburg, FL; and Salem, OR. New Haven was excluded from this study.

Families who participate in center sessions less than once per quarter receive considerably fewer home visits than families who come to the center regularly. Families in the latter group were visited nearly two times per month on the average, while those in the other group were seen less than once a month. Only in Oklahoma City and Las Vegas, the two sites with the lowest levels of center participation, was frequency of home visits approximately the same for the two groups of families. It appears that families with low levels of participation are simply less committed to CFRP than other families served by the program, perhaps due to a lack of interest or motivation to participate or, in the opinion of parents, less need for CFRP services.

Home visit frequency is dictated to some extent by family worker caseloads: visits occur less often where caseloads exceed 20 families, which is not uncommon in some CFRPs. There also appears to be a relationship between the home visit planning effort and the frequency with which home visits occur: frequency decreases when home visiting staff do their own planning and have no curriculum or supervisor to fall back on for help.

In most programs, home visits have a dual focus: (1) helping parents to become more effective in their role as educators of their own children; and (2) helping parents to meet a broad range of family needs and concerns. In some programs, the dual focus of the home visit is explicitly recognized, and separate family workers are assigned responsibility for each aspect. Two different models of home visit assignments are currently in place within local CFRPs:

- The Team Model--employed at two sites--was developed to ensure that both parent education concerns and family needs are addressed adequately in home visits. Visits are conducted by two

family workers: one has responsibility for working with the parent and child on issues related to the child's development and parenting skills; the other focuses more broadly on family needs.

- The Single Worker Model--employed at all other sites--assigns one family worker to each family, with responsibility for both aspects of the home visit, child development and parenting issues as well as family needs.

While participation in center sessions and home visits was lower in the Las Vegas and Oklahoma City programs, total contact with families was about the same at the five sites. Contacts with families in Las Vegas and Oklahoma City were simply of a different, more informal nature (mainly telephone calls). On average, there were about 14 contacts per quarter with each family, a little less than five per month. Total participation in center sessions and home visits appears to have declined during the first year in the program and then leveled off in the second year. The decrease in number of home visits from 6 to 3 per quarter was particularly dramatic.

Head Start

Head Start at the eleven CFRP sites is very much like Head Start elsewhere across the country, with two important differences:

- Where Head Start is connected to CFRP, there is likely to be greater continuity for children and parents, with a smoothing of the transitions at both ends of Head Start--from the infant-toddler component, and to the elementary school.

- CFRP families with children in Head Start continue to receive the broader spectrum of services for family needs associated with CFRP.

In most programs, CFRP children are guaranteed a slot in Head Start or at least given priority for enrollment. However, in the "separate programs" model (discussed earlier), there is considerable uncertainly about the child's entry into Head Start.

CFRP/Head Start is more than a direct intervention program for preschoolers. Classroom activities are supplemented by periodic home visits and center-based parent sessions. Opportunities also are provided in most programs for parents to volunteer in Head Start classrooms. In some programs, the frequency with which home visits and center sessions occur decreases when the child enters Head Start; at other sites, the schedule remains the same or increases in frequency. However, there does appear to be a decrease in emphasis on the parent as the primary educator of her own children. The focus of home visits is mostly on helping families to meet their needs and not on educational concerns. This is particularly evident in some programs where CFRP is viewed as the "social service" component of Head Start.

Mechanisms used to provide continuity from infant-toddler to Head Start include: having the same family worker continue working with the family; conferences between family workers and Head Start classroom staff; sharing of records; and, in some programs, joint assessments of family and child needs, as well as development and implementation of family action plans. There are differences in the extent to which these approaches have been adopted in the eleven CFRPs.

Preschool-School Linkage Component

The preschool-school linkage (PSL) component is the least clearly defined and well-developed of the three major CFRP components. Some transitional services are provided as part of this component. They often include orientation of

children, their parents, and schools; trouble-shooting in response to requests from parents or school personnel; and tutoring of children either by CFRP staff or through referral to community tutorial services. Other common practices are sharing children's records with the public schools and assisting in the placement of special needs children.

Linkages have been established with public schools at all eleven sites. The linkage system is often limited, however, to establishing contact with schools, finding out about registration procedures, and informing schools about the CFRP children that will enter. Comprehensive follow-up on all school-age children in CFRP is not feasible in most programs due to resource limitations. Program intervention is usually limited to special problem cases that have been identified either by parents or school personnel.

Six programs continue to make regular home visits to PSL families once their youngest child enters school; as a general rule, these home visits are less comprehensive in nature. Other programs make visits only if a particular school-related problem arises. Most programs do not conduct any center sessions that are specifically aimed at parents of school-age children. Instead, parents are invited to attend center sessions conducted as part of other CFRP components.

The limitation on the resources allocated to the PSL component at most sites raises some doubt about CFRP's ability to provide effective continuity to children and parents at the point of entry into elementary school.

What kinds of services are provided to CFRP families?

All CFRPs have established an extensive network of linkages with social service agencies in order to reduce fragmentation of community services for families--to give them

one place where they can turn for help from a variety of programs. The process of building a network may be simply described as one of people meeting people. In most programs, this typically has become a system of "interlocking directorates," with CFRP staff sitting on boards or committees of other agencies, agency staff sitting on CFRP and Head Start boards and committees, and both sitting on interagency councils. At some sites CFRP has played an instrumental role in setting up such councils to increase communication and cooperation among agencies.

The CFRP network of linkages is far more comprehensive than is generally the case in Head Start programs. The Head Start linkages which at almost all sites were used as a base were expanded or changed in scope when CFRP was initiated. At some sites, this simply meant adding one or two agencies to the existing network; at others, CFRP had to establish relationships with various community agencies and interact with agency personnel in different ways.

The most obvious benefits of CFRP/agency linkages are improved access to agency services. When relationships are poor, it is families that suffer. At times, the benefits of CFRP linkages go beyond the client population and have a broader impact on the community at large. CFRPs at several sites have been strong advocates for change to ensure that resources are made available to low-income families.

All programs appear to be doing an effective job of making sure that families receive the services they need, although the degree of effectiveness varies from program to program. At all sites, CFRP is demonstrating that linkage networks with other community service agencies can be established and that access to services can be improved. This aspect of the program is a model of interagency cooperation which could well be replicated in other communities.

Every CFRP provides developmental services to children (including developmental assessments at most sites) and educational services to their parents. Staff from nearly every program list counseling among the services they provide directly to parents. Other direct services, offered at selected sites, include health and nutrition screening and immunizations; various types of treatment, such as speech therapy or the services of a dental hygienist; day care; job counseling; legal advice; recreational opportunities; and even, at one site, translating services. In general, these services are provided directly by CFRP either because they are not available elsewhere or because their availability is in some way hampered by inadequate resources, agency attitudes, or other access problems.

CFRP staff differ from site to site. however, in the degree to which they prefer to provide services directly as opposed to referring families to other, more specialized agencies to receive services. It is possible to identify two models, at the extremes on this preference scale:

- The Direct Services Model applies to programs in which staff see themselves as being primarily service-providers. Outside personnel are often hired to offer specialized services within the program because of this preference for direct provision.

- The Community Linkage Model applies to programs in which staff see themselves primarily as providing a connection to appropriate community resources--that is, where family needs (as opposed to child development and parent education needs) are concerned. Few outside people are hired to offer specialized services within the program; rather, families are sent outside to get such services.

No CFRP fits either model precisely: staff at all sites refer when necessary. Nevertheless, these models do provide a useful device for understanding a genuine difference between programs. In actuality, every CFRP probably falls somewhere between these two extremes.

How are program services individualized?

One of the mandates of CFRP is to individualize and tailor program services to meet specific family and child needs. In order to do so, it is necessary to assess the needs of each family at the time of entry into the program and to reassess those needs periodically. Reassessments occur once a year at some sites, and more often in other programs. At most sites, the reassessment process involves a team of staff, who review the needs data which have been gathered by the family workers. There are some site differences in the types of staff involved.

The reassessment usually leads to development of a new family action plan or revision of an existing plan. The plan is the product of mutual agreement between the parents and family worker and serves as a basis for individualization of program services to meet the needs identified and pursue the goals set. According to family workers, for the CFRP families in the process/treatment study major emphasis was placed on child development and parenting skills. Program emphasis varied, however, from site to site; for example, in Las Vegas more emphasis was placed on job training than on child development or parenting concerns. Not surprisingly, there appears to be a connection between the issues discussed in reassessment and those emphasized on an ongoing basis by program staff.

In addition to the more formal approach to identification of family needs and of steps towards meeting those needs represented by reassessment, there is a less formal on-

going process which usually involves only the parents and the family workers. This is the process of setting goals and working toward their fulfillment--the regular agenda of home visits. The goals set arise out of family needs as perceived by the parent and the family worker. This dual perspective is reflected in the types of goals set.

The CFRP families in the process/treatment study set an average of 7.4 goals during their first 21 months in the program. Of this total, 4.7 goals were set in Year 1 and 2.6 in Year 2. A number of the goals set in Year 1 were carried over into the second year; in fact, there were a total of about 6 active goals per family on average in Year 2. Once again, parenting and/or child development were a common focus of goals at all sites. There were some site differences, however, which can be interpreted as representing alternate program approaches. In Salem and Jackson, more families had goals in the area of parenting skills and parent-child interaction than in that of child development per se; the opposite was the case in Las Vegas, while in Oklahoma City and St. Petersburg there were about equal numbers of families with goals in each area. It is of interest to note that improving financial circumstances or obtaining assistance in making ends meet were goals for a fairly small proportion of the families. Needs for this kind of assistance--which may include getting help paying energy or housing bills or extra money to buy food or clothing--often are short-term, and most likely are being addressed through referrals rather than being identified as family goals. The profile of family goals set over the reporting period remained relatively constant.

A major purpose of reassessment is to evaluate the family's progress--as well as the effectiveness of the program in meeting their needs. The issue of program effectiveness is addressed in Chapter 3.

Chapter 3

PROGRAM EFFECTS AFTER EIGHTEEN MONTHS

The central question addressed in this chapter is whether CFRP had an effect on families after a year and a half in the program. CFRP families were compared with a group of families not enrolled in the program on five outcome domains: family circumstances, parental independence and coping ability, health, parent-child interaction, and child development. These domains are closely linked to CFRP objectives, and therefore are likely to be affected by family participation in the program.

1. Is there evidence after 18 months of program participation that CFRP is effective for parents?

YES in the area of parent-child interaction. Results from the Toddler-Infant Experiences System* observation study conducted jointly with Research for Children of Menlo Park, California, provide the clearest evidence to date that CFRP is having an impact on the families served by the program. Observation data obtained at two sites (Oklahoma City and St. Petersburg) show several significant differences between the CFRP and control/comparison groups in both amount and patterns of parent-child interaction. CFRP children spent significantly more of their time interacting with parents than non-CFRP children. When interactions occurred, CFRP mothers did more teaching than mothers in the control/comparison group, most frequently of language skills. Interactions between parent and child involving language information occurred more frequently in the CFRP group. Further, CFRP children showed more attempts at mastery of language and motor skills than children in the control/comparison group. These positive effects on parent-child interaction may eventually lead to enhanced child development, which is CFRP's major goal.

*Developed by Jean V. Carew.

PERHAPS in medical care of mothers. A significantly higher proportion of CFRP mothers than of mothers in the control/comparison group were receiving treatment for health problems. No group differences were found, however, on ratings of the general health status of the mother, length of time since the last medical checkup, prenatal care (for younger siblings of the focal child), or various factors associated with the medical facilities used by families.

NO in improving family circumstances. All indications are that CFRP has not been able to improve the circumstances of families in the eighteen months since they enrolled in the program. Average family income is lower for the CFRP group than for the control/comparison group, perhaps partly due to higher maternal unemployment and less reliance on earned income in the CFRP group. The high unemployment of CFRP mothers is not surprising, given the fact that the program is simply not set up to serve working mothers very effectively. Some CFRP family workers even recommend that mothers quit work and go on welfare so that they can concentrate on parenting. Enrollment in two public assistance programs (AFDC or welfare and food stamps) was significantly higher for the CFRP group.

In the short run, employment may be neither feasible--especially for mothers of young children--nor effective as a means of improving family circumstances; it actually may lower total family income if it renders the family no longer eligible for public assistance programs. A good way to improve the long-term economic outlook for families, however, is to increase parents' eligibility for better, higher-paying jobs. Approximately the same proportions of CFRP and non-CFRP mothers had obtained job training in the year prior to the interview. An alternative, still more long-range approach would be to upgrade mothers' educational status. A program effect was evident in this area: more CFRP than non-CFRP mothers were planning to continue their education.

There was no evidence of CFRP impact on housing quality or parents' satisfaction with housing.

YES in increasing access to community services and support. There is evidence that participation in CFRP has resulted in increased knowledge of resources in the community, improved access to community services, and in some instances increased utilization of services as well. For example, a significantly higher proportion of CFRP mothers than of non-CFRP mothers had received help finding health care services. CFRP families tend to rely on CFRP and other agencies for help whereas non-CFRP families rely more on relatives and friends. Similar types of help are used by families to solve their transportation problems, which frequently are a major obstacle to obtaining needed services.

This might be taken to suggest that--to some degree, at least--the program is replacing the informal support networks typically used by families. This interpretation is not supported by CFRP family workers, who see most of their families as usually independent or very independent of the program.

Parents' ability to cope with their living circumstances and meet their needs may be influenced greatly by the extent to which they are affiliated with support systems in the community. There is some evidence of a CFRP effect in this area. CFRP mothers have somewhat more social interaction with parent groups than non-CFRP mothers. This is largely attributable to the fact that some CFRP mothers participate in parent groups offered by the program itself which are not available to mothers in the non-CFRP group. These group sessions are commonly viewed as providing "support" to parents in raising their families.

2. Is CFRP effective in enhancing the development of infants and toddlers?

NOT YET in the area of mental and physical development. After a year to a year and a half of program participation, CFRP children were not found to differ significantly from control/comparison children on mental and physical development scores of the Bayley Scales of Infant Development (BSID). There was an indication of a positive CFRP impact on mental development at only one of the six sites. However, there were hints of a possible participation effect--with children from families who participated actively in program activities achieving higher scores.

There is some question as to the appropriateness of the BSID for measuring CFRP impact. Further, it is possible that CFRP impact on child development is simply too indirect to be detected after a year to 18 months of program involvement. Parents may have to change first, before their children are likely to be affected. There is reason to believe that positive changes in the area of parent-child interaction will eventually result in (measurably) enhanced development of CFRP children.*

NO in child health or medical care. Several aspects of the child's health were assessed--height and weight measurements, and parent reports on general health status, health problems and handicaps, treatment for health problems, length of time since last medical checkup, and immunizations. Only in the area of immunizations was a group difference evident--a higher proportion of the CFRP group of children had been immunized against measles, mumps, and rubella (MMR) than was the case in the control/comparison group. However, the two groups were comparable in terms of other child immunizations. It is important to note that not all CFRP children in some programs have received proper immunizations.

*The next assessment of children's development will occur in fall 1981, at entry into Head Start.

3. Do CFRP parents and staff report any program effects?

YES, especially in the area of parenting. CFRP parents checked an average of three to six topical areas in which they had learned or benefited from CFRP participation. About one-fourth (23%) indicated that they had learned more about child development and parenting than about any other topic. Health also ranked high, followed by education. Family workers agreed, indicating that they had observed progress within many of these families in the areas of parenting, health, and education.

Chapter 4

PROGRAM STRENGTHS AND WEAKNESSES AND FUTURE STUDY ISSUES

The findings presented in the previous two chapters provide convincing evidence that CFRP is accomplishing many of the objectives it set out to achieve. Among the program's major strengths are:

- Effective tailoring of program services to meet the needs of individual families.
- Assisting parents to set goals for themselves and to achieve those goals.
- Establishing networks of linkages with community service agencies, resulting in increased parental knowledge of resources in the community, improved access, and in some instances increased utilization of services.
- Providing a child development program that is oriented toward the family, with strong emphasis placed on parents as educators of their own children.* This has resulted in positive changes both in amount and types of parent-child interactions.

Some program weaknesses also have been identified in the 18-month evaluation. Findings to date suggest that the program could be strengthened considerably in the following areas:

- Increasing family participation in home visits, and particularly in center sessions. The "less than optimal" levels of participation by study families severely weaken the program's potential effects in the areas of parenting skills and child development.

*This finding is based on staff and parent reports rather than direct observation of what actually occurs. This issue will be investigated in greater depth in the ethnographic study.

- Shifting program contact in some sites from telephone calls and brief home visits to major program activities. The former types of contact may not be conducive to achieving overall program objectives.

- Strengthening the health component of CFRP to ensure, at a minimum, that all children are immunized.

- Exploring ways to improve the financial circumstances of families and to help parents break the poverty cycle in the long run.

- Finding ways to serve working mothers more effectively so that they can benefit from the services offered by CFRP. Attempts thus far have met with only limited success. Working mothers either become inactive participants, drop out altogether, or are encouraged (in some programs at least) to quit work in order to devote full time to parenting.

Future Study Issues

The 18-month findings suggest several areas of inquiry that should be pursued in subsequent phases of the CFRP evaluation. Future study issues are identified and discussed below.

Infant-Toddler Component. The infant-toddler component of CFRP has been the major focus of the CFRP evaluation to date, in accordance with the design specified for the study. This has been particularly appropriate in light of the fact that in a number of programs the infant-toddler component is viewed as one of the major features that distinguish CFRP from Head Start. In some programs, the infant-toddler component is in fact synonymous with CFRP; in most, it is the most fully implemented program component.

The picture obtained thus far is incomplete, however, in that the most recent data were collected when families had participated in only 18 months of the infant-toddler program, which typically spans three years. Much has been learned during this time period about the processes used to deliver services, the treatment itself, and impact on families and their children. In order to gain a more complete understanding of CFRP as a family-oriented child development program, it will be necessary to continue to study this component in the next phase of the evaluation. In particular, we must examine changes that occur over time in program processes, treatment, and effects--issues addressed in both the process/treatment and impact studies of the CFRP evaluation.

One of the issues to be examined in Phase IV is whether CFRP affects families in different ways as they progress through the program. Many family goals are necessarily long-term in nature, and it may take some time--perhaps considerably more than 18 months--for program effects to show up. It is not unrealistic to assume, for example, that the entry into Head Start of focal children in fall 1981 will provide parents with new opportunities to pursue some of the goals that were set earlier and on which little or no progress has been made to date. Mothers may implement their plans to further their education, become enrolled in job training programs, or join the work force in an attempt to decrease their dependence on public assistance programs and improve the financial circumstances of the family. Continuing to collect data on goals will increase the chances of detecting CFRP effects.

We also propose to continue the collection of data on family participation in program activities. The rationale for this is two-fold: (1) links have been found both in the CFRP evaluation and in other studies between high participation levels and positive outcomes, particularly in the areas of

child development and parent-child interaction; and (2) it appears that participation of study families is consistently lower than for non-study families enrolled in CFRP. These issues warrant further investigation, particularly since child development outcomes will be a major focus of Phase IV. A post-infant-toddler and pre-Head Start assessment will be conducted in fall 1981, when most children are expected to make the transition from infant-toddler to Head Start. In addition, we plan to collect participation data on all CFRP families enrolled in the infant-toddler component at the five process/treatment sites in an attempt to verify staff reports that participation is significantly lower for study families because they were recruited for the evaluation and did not seek out the program for help. This substudy will take place in spring, prior to the entry of the children into Head Start. If staff reports are substantiated in this substudy, it will weaken the generalizability of evaluation findings. Furthermore, it will provide important information about the types of families that are most effectively served by a program like CFRP.

While the major focus of the impact study in Phase IV will be on child development--and perhaps on parental teaching skills--plans call for the continued collection of data, by means of parent interviews, in other outcome domains: health, family circumstances, and community services and support networks. Limiting the focus of Phase IV to child development assessments would provide too narrow a view of the potential effects of CFRP. Furthermore, the examination of the family development process begun in Phase III with the collection of data on family needs and strengths would be left incomplete if no more information in these other domains were forthcoming. In addition, interviews with CFRP parents and family workers will continue to deal with issues such as levels of program participation, the program's emphases with each family, areas in which the

family has benefited from program participation, and the degree of the family's dependence on CFRP and on other agencies; these data will yield information on changes in program processes and treatment, as well as on changes in families.

Finally, the results of the ethnographic study currently being carried out in the five process/treatment programs will contribute significantly to gaining a complete understanding of the infant-toddler component of CFRP as it is experienced by eight families at each site. Data are being collected over a six-month period, with a report to be issued in fall 1981.

Infant-Toddler/Head Start Transition. The transition from the infant-toddler component to Head Start will be another major focus of Phase IV of the CFRP evaluation. Little is known to date about the processes used by CFRP to ensure developmental continuity during the major stages of the child's development (from before birth to early grades in elementary school). Preliminary findings from the program study raise some questions about CFRP's ability to fulfill its promise to afford such continuity at the point of transition from the infant-toddler component to Head Start, and even more so at the point of entry into elementary school. This issue will be explored in greater depth in fall 1981, when the focal children enter Head Start. Preliminary plans call for conducting interviews with Head Start teachers, family workers, and parents to gain a better understanding of how developmental continuity is attained.

An important question to be addressed in the CFRP evaluation is what incremental benefits families and children derive from participation in CFRP, compared to a group receiving only Head Start services. In order to examine this issue, the research design calls for the entry of both CFRP and control/comparison children into Head Start in fall

1981, or when the children meet age guidelines established by Head Start. The design will be implemented at five of the six sites; in Salem, a lack of Head Start slots prevents the control/comparison children from entering the program.

Thus there will be a major shift in the focus of the impact study component of the evaluation. In the first three phases, the effects of CFRP were determined by comparing a group of families enrolled in CFRP with a group receiving no program services. In subsequent phases, comparisons will be between two groups of families both enrolled in Head Start. The CFRP group will have participated in the program for three years prior to entry into Head Start and will continue to receive the broader set of services offered by CFRP. In contrast, the control/comparison group will not have received any program services prior to entry into Head Start, and the Head Start services offered to these families at some sites will be less extensive in nature than those provided to families enrolled in CFRP.

In order to assess the incremental benefits of CFRP, it is critical not only to have a complete understanding of the treatment families received in CFRP's infant-toddler component, but also to determine similarities and differences in the Head Start experiences of the two groups of families. For example, is more contact maintained with CFRP families than with the Head Start-only group? Are the services provided to CFRP families more comprehensive than those offered to Head Start families? In subsequent phases of the evaluation, we plan to address this issue by continuing to collect some information on the processes used to deliver services and the Head Start/CFRP treatment, and particularly on the participation of families and children in program activities offered by CFRP and Head Start.